To: Women's Health Committee

From: Rivka Weiser, Department of Social Services

Date: October 15, 2012

Re: Obstetrics Pay-for-Performance Program: Key Design Issues and Potential Directions

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To assist in our renewed discussions of the Obstetrics Pay-for-Performance (P4P) program, below is a summary of some of the key design issues that have been under discussion and broadly shape the design and structure of the initiative.

In the time since this initiative was last discussed in detail with external stakeholders, Community Health Network (CHN) has been developing and testing a prenatal registration system, which gathers detailed information on pregnant women and prenatal care, and will be discussed in greater detail at the meeting. The Department is focusing on this system, which can be easily scaled up for use by additional providers, as a promising and relatively simple potential source of information for the P4P program.

The Department continues to be committed to implementing the P4P program, and we look forward to further discussion in order to help finalize the program's design. Throughout this memo, decision points and potential directions are presented to facilitate discussion among this Committee's members and other stakeholders.

1. **Structure of performance recognition – aggregating at the obstetrics neighborhood (ON) or provider group level:**

Decision point: A key area of discussion has centered on the best level of aggregation for measuring and rewarding performance – at the obstetrics neighborhood (ON) level (basically, a hospital and its affiliated obstetrics providers), or at the level of a particular provider group. Conceptually, some prefer an ON-based approach that would pool providers by hospital and perhaps encourage more collaboration or movement on measures in which hospital-level policies are influential. However, provider-level measures might more successfully incentivize providers to attend to quality in their practice, as opposed to having measures pooled and quality indicators diluted at the hospital level, without recognizing quality variation across providers. Measures at the provider level, however, could lead to issues of measure stability for the many providers who do not have large numbers of deliveries. To address provider-level quality while allowing a practice of any size to reliably participate, rewards could essentially be attached at the individual client level, as discussed in the next paragraph.

Potential direction: The Department is considering basing the P4P on client-level data largely from CHN's registration system (perhaps supplemented by claims). For example, for a given client, data from the registration system could be evaluated for particular aspects of prenatal and postnatal care provided (to be discussed), and a practice could be awarded a specified number of "points" or receive a score based on care provided to a client. Advantages of this system include its simplicity, and that it attaches rewards at a particular client level and automatically adjusts for client volume in a practice (instead of calculating a measure with a denominator, and then essentially multiplying the denominator out when adjusting for volume). This client-based structure includes incentives to provide good care for every single client and encourages improvement at any level -- there would be no need to determine specific levels of practice performance or improvement to reward (e.g., for measure X, we reward Y points if a practice scores above 80% and Z points if above 90%).

This type of system could also be structured to disproportionately reward activities or performance related to particular groups of clients (for example, teens who are pregnant, or those with particular risk factors) without the need for complex risk-adjustment of measures.

2. **Selection of measures (including consideration of data sources and challenges)**:

Decision point: We will need to select which measures will be the basis for assessing and rewarding performance. Challenges in measure selection include whether or how to account for differing risk profiles of the populations seen by practices or hospitals, and selecting measures that reflect provider quality/effort and can be influenced by the provider. Once measures are selected, we will also need to determine how to translate them in to P4P rewards (for example, measure baseline and then improvement, compare measures to particular thresholds, attach scoring or points for a particular client, etc). A workgroup that met previously developed a set of potential measures of interest to select from for the initiative -- such as adequacy and timeliness of prenatal care, prematurity, primary Cesarean section rate, participation in the Rewards to Quit smoking cessation initiative, low birth weight, elective delivery, readmissions, and postpartum visits. Selecting a few most practical and valuable core measures from this set would help focus the initiative further.

Depending on the measure, relevant data sources can include claims, client medical records, CHN's prenatal registration system, and/or DPH birth certificate data. Each data source has its own associated challenges that must be considered in P4P program implementation (for example, the burden of record review, the timeliness of birth certificate data availability).

Potential direction: CHN's registration system can be used to focus on aspects of prenatal and postnatal care provided (to be discussed). As discussed above, primarily using CHN's registration system might be a useful and relatively straightforward way to implement the P4P program at this point, and could help simplify implementation of the initiative. Further discussion is warranted regarding which elements to include and whether any changes should be made to the data elements gathered.

Some measures that have been considered for P4P (such as primary Cesarean section rate, low birth weight) do not seem to easily lend themselves to this approach, may be best aggregated at the hospital/community level, and/or may need some form of risk-adjustment. The Department can consider developing, refining, and including such measures in the future as we gain further experience in the P4P program and the initial measures that are more directly tied to care provided by a provider.

3. **Provider sign up versus automatic enrollment:**

Decision point: Another key design question is whether providers would automatically be enrolled and rewarded, or would need to sign up or opt-in. An opt-in would allow the Department to attach particular requirements to participation (for example, participation in the Rewards to Quit smoking cessation program) and might be better for motivating and organizing committed providers around the goal of quality improvement. However a more automatic enrollment of providers would greatly increase the reach of the program and expand the potential for care improvements for all clients.

Potential direction: This issue remains an open question for discussion. If the program is largely based on CHN's registration system, as discussed above, it can be scaled to large numbers of providers relatively easily. The Department can also consider ways in which the P4P structure might incorporate rewards for specific activities that we want to encourage, instead of having a more formal opt-in process. For example, once Rewards to Quit is being implemented, additional associated P4P rewards could perhaps be added to the Obstetrics P4P – such as for client referral to or enrollment in Rewards to Quit.

We look forward to further discussion of these and other issues in implementing the Obstetrics P4P program, and to developing a plan for program implementation.